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Hurting and healing in therapeutic environments: How can we understand the role of the relational context?

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Abstract

It has long been recognized that relationships are key to good mental health service delivery and yet the quality of the relational context remains poorly understood. This article brings together three studies that utilize very different methodologies to explore the various ways in which a process of therapeutic change can be aided or prevented by relational factors. All three studies took place within the context of therapeutic communities. The first study uses narrative ethnography and interaction ritual theory to explain how the mechanisms of everyday encounters in two therapeutic communities transform negative feeling into a sense of belonging and positive emotions such as confidence. The second study uses grounded theory to explore how the relational setting and the altered context of the researcher in a therapeutic faith community environment induces either a positive or negative quality of relationships. The final study uses a novel autoethnographic methodology to inform understanding of the relational experience of mental health treatment by comparing and contrasting multiple perspectives of different treatment environments. The paper concludes by identifying the expression and containment of affect in a congruent environment, belonging and hope, and fluid hierarchies of relational structures as key aspects of the relational context informing change.

Key words:

Therapeutic communities; mental health; relationships; power; qualitative methods

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Introduction

Relationships are implicated in both “the creation and amelioration of mental health problems” (Pilgrim, Rogers & Bentall, 2009, p. 235). Or, as one member of a therapeutic community put it, “it is people that hurt us and people that heal us”. These statements have found strong support in the research literature: from the role of attachment as both a significant predictor of psychological difficulties and as a resilience factor against stress (Ma, 2006), to the quality of the therapeutic alliance as the most consistently reliable predictor of psychotherapeutic outcome (Lambert & Barley, 2001). In these terms, relationships are not just an important aspect of any mental health intervention – they *are* the intervention (Middleton, 2015).

However, despite the evidence suggesting relationships are both the cause and solution of most mental health problems, surprisingly little has been written about the specific qualities of the relational ‘climate’ that are likely to contribute to positive or negative emotional effects. One of the exceptions to this is Carl Rogers. Rogers (1961) identified three core conditions that he believed needed to be present in the therapeutic relationship to establish ‘contact’ and provide the stimulus for positive behavioural change in a therapeutic setting. These interrelated factors included congruence (the willingness on the part of the therapist to be genuine and authentic), unconditional positive regard (the therapist’s communication of total and complete acceptance of the client, without judgment) and empathy (the therapist’s communication of their desire to understand and help the client). Rogers’ theories have been highly influential in psychotherapy and have been supported by numerous empirical studies (Joseph & Murphy, 2013).

Foremost in Rogers’ system was the role of the therapist as the principal creator of the relational climate necessary for personal change. However, in doing so it is possible that

Rogers overstated whether these conditions were truly possible in therapy. In the celebrated dialogues between Rogers and other key thinkers of his time (Rogers, Kirschenbaum & Henderson, 1989) the philosopher and theologian Martin Buber questioned whether a true sense of mutuality could really exist between therapist and client given the structural aspects of the therapeutic relationship and the obvious power differential between the two parties. In other words, it would be very difficult to conceive of a truly I-Thou relationship in Buber's (1937) terms when one person was seeking help from another person very different in status and role.

It is worth pointing out that Buber did not say that he believed contact was impossible between two people in therapy, only that there were limitations inherent in the therapeutic situation (Rogers et al., 1989). These limitations were also recognised by early pioneers of the therapeutic community (TC) movement (Winship, 2013). Working with traumatised veterans following World War II, psychiatrists such as Wilfred Bion, Tom Main, Michael Foulkes and Maxwell Jones discovered that involving patients in all aspects of the running of the hospital led to vastly improved outcomes (Manning, 1989). Devolving the natural power structures between staff and patient (named 'flattened hierarchy' by Rapoport, 1960) became a key aspect of later TCs (Campling, 2001) along with the harnessing of peer relationships between members as a powerful therapeutic resource (Spandler, 2006). These innovations arguably anticipated the rise of several innovations in mental health services, including the recovery approach (Winship, 2016) and service user involvement (Haigh, 2004).

Whilst there have been numerous studies focusing on treatment effectiveness and clinical outcomes (e.g. Lees, Manning & Rawlings, 1999; Capone, Schroder, Clarke & Braham, 2016), there have been relatively few studies that explore how the quality of interactions within TCs facilitates personal change. There have also been few studies that have looked at the influence of the relational context on the quality of the social interactions

within TCs. Thus, whilst it is possible to point towards structural innovations in TCs such as democracy and peer support, the actual quality of the relational context in TCs, like in mental health generally, remains poorly understood.

This article presents three studies that attempt to address these issues using different qualitative methodologies. The three studies were selected because they each highlight different, yet interrelated, aspects of the quality of relationships in TCs. As far as the authors are aware, these are the only studies on TCs that have focussed on how the quality of relationships impact upon personal change.

The methods and results from each study are presented concurrently. A detailed analysis and discussion then brings together and examines the interrelated themes across all of the studies. These three studies together show a number of overarching themes. These include the importance of the everyday interaction between TC members, the role of context in determining the quality of the interactions, the communal dimension of hope, and the difference between professionalised and non-professionalised roles in TCs and psychiatric healthcare.

Study 1

Methods

J.M. Clarke's study investigated how everyday interactions supported personal change in two adult-democratic TCs for individuals with a diagnosis of personality disorder. Drawing on Interaction Ritual (IR) theory (Durkheim 1912/2001; Goffman, 1967; Collins, 2004), the study explored the role of emotions, feelings of inclusion and how power is used during everyday interactions. An interaction ritual is a social encounter whereby individuals share their attention and emotion, generating feelings of group belonging, symbols of group

membership and social expectations, or moral codes, for interaction (Collins, 2004). Social meanings that arise from interactions are fluid, reflective and continuously evolving. Key to IR theory is the role of emotions, as individuals will be drawn to repeat those interactions that provide the highest emotional reward (Collins, 2004). Additionally, Collins (2004) highlights that interaction rituals have a history and future and are linked together through 'chains'. These chains over time form social rules and expectations in groups and within individuals. How groups manage these social rules within interactions, and whether they mutually experience positive emotional feeling, indicates the relational quality between members. Summers-Effler (2004) distinguishes between 'power' rituals and 'solidarity' rituals. With power rituals, the positive emotional feeling is consolidated with the dominant members gaining positive feeling whilst the subordinates lose it and the relational dynamic is unequal. In contrast, in solidarity rituals all members, regardless of status, share the positive emotional feeling and the relational dynamic is mutual. Within a TC, examples of interaction rituals include mealtimes, smoking breaks, community meetings and grocery shopping. As IR theory explains social mechanisms of interactions, it is ideally placed to analyse the role of social encounters within TCs and provides a framework understanding issues of power.

The study used a narrative ethnographic approach to examine the mechanisms of social interactions outside of structured therapy and the relational dynamics between client members. Both TCs' therapy duration was 8-12 months and are anonymised in this article as 'Powell', a residential TC, and 'Hawthorne', a day programme TC. Ethical approval for the study was granted by Nottingham Research Ethics Committee 1 in the UK. Specific methods of data collection included: over 700-hours of participant observation; in-depth narrative interviews with 21 client members; semi-structured interviews with 7 selected staff members; and document analysis of community leaflets, list of social rules, forms for

boundary or rule breaks, and excerpts of clients' reflective writing. The participant observation focused on times outside of structured therapy, such as community meetings, smoking breaks and meal times. At the residential community this included days, evenings, nights and weekends, and at the day community, times in between structured therapy groups. Interviews with clients explored their experiences being in the TCs, whilst interviews with staff members focused on contextualising information about their respective TCs and approach to overall therapy. Data analysis was interpretivist and thematic, with data being coded for key themes and interaction rituals chains. Fieldnotes were read in entirety for initial themes, particularly around inclusion, power and emotions, and then loaded into NVivo for further analysis and coding. Interviews were transcribed verbatim, forming the first stage of analysis (Langellier, 2001) and analysed holistically in order to closely analyse themes within a given narrative, and then cross-referenced with other interviews and fieldnote data.

Results

The research highlights that during everyday social interactions such as meal times, smoking breaks and informal times, maintaining solidarity between client members is important in the presence of negative emotions. It is through feelings of inclusion that negative emotions can be transformed into positive feeling, as the following extract from Powell illustrates:

It is nearly 9pm and I join some of the clients in the lounge. Julie, who is sitting with Anna on the sofa, is sobbing. Julie is explaining she wants to leave the unit but her mum will not come get her. Erica is colouring but clearly listening to the conversation. Julie says the only

time her mum really seemed “bothered” about her is when she jumped off the roof. Erica asks Julie about her urges and Julie says she does not feel safe and that is why she is in the lounge. Margaret (nurse) then comes in and joins the conversation. Talk revolves around Julie's eating disorder. Anna at times pats Julie's leg, and tells her she will get to the point where she can picture life without the disorder. She reminds Julie that the eating disorder is not her friend and does not help or protect her - it will kill her. Julie is crying and loudly sniffing. After a while the conversation moves on but every now and again someone will either gently pat Julie's shoulder or quickly check in with her.

Though there was anxiety surrounding Julie's distress, everyone stayed in the lounge, including Anna and Erica. Equally, Julie could have retreated to her room. Crucially, it seems individuals will tolerate negative emotions if over time they receive positive ‘payoffs’ from the interaction (Turner and Stets, 2005). Not only did Julie receive support and feelings of inclusivity from the group, but so too did those who remained in the lounge by giving their support. Moreover, the expression of negative emotions was often a motivator for community members to draw *together* rather than to isolate. Clients will still interact with one another, even if there are high levels of negative emotions, if group solidarity remains intact. This is akin to Collins's (2004) assertion that negative emotions can still generate long-term positive feeling if members come away with feelings of belonging.

Importantly, feelings of belonging and inclusion can help facilitate personal change. In total, 16 of 21 client members from both TCs explained their experience in working through negative emotions together had given them increased feelings of confidence and self-acceptance. Heather from Hawthorne said, ‘They helped with my confidence, they helped

me deal with facing things. [...] I have this sense of feeling in myself that I know I'm going to be okay'. Echoing Heather's comments on confidence, Erika from Powell stated, 'I feel a lot more confident in that I don't have to act on urges'.

However, not all clients related feelings of positive changes or social inclusion through relationships. Robert from Hawthorne was consistently excluded from client member social interactions within the TC. During his interview, he explained:

I've tried to join in more, I've tried to make more uh, give more feedback if you like. But...I still don't feel a part of the group. I feel like there's everybody else and me. So...that gets me down, that I'm not a part of it.

Robert's comment suggests social exclusion was sometimes present within client member relationships. He later went on to explain in his interview he felt there was a 'pecking order' and he was at the 'bottom'. Other clients also spoke of an invisible hierarchy based on things including length of time in the community, things they have in common, age and gender. Therefore, Robert's comments provide a challenge to traditional TC notions of a 'flattened' hierarchy (Rapoport, 1960; i.e. whereby all client and staff have equal status within the community). Instead, Clarke (2015) proposes a 'fluid' hierarchy, which is discussed in more detail in the discussion section.

Study 2

Method

Brown's study used a mixed methodological approach to investigate key factors involved in personal, positive change in the context of a therapeutic community. Data was collected over

a two-year period from newcomers to Christ Church Deal (CCD), an open (i.e. non-residential) therapeutic faith community run by 'lay' members (Holmes & Williams, 2010). Throughout the study, Brown occupied numerous roles inside the community, including as a client member and a member of the Risk Management Team. Outside of the community, she worked as a specialist mental health pharmacist in the NHS and studied as a doctoral student. Brown adopted the perspective of 'the space between' (Dwyer and Buckle, 2009) both insider and outsider status. Standard psychiatric outcome measures were used at baseline and six-month intervals for those who joined the TC between 2007 and 2008. The qualitative method involved collecting data from questionnaires and in-depth interviews. Only the data from the in-depth interviews is discussed in this article. For the interview, participants were encouraged to tell their story about their previous experiences of mental health services and professionals, being interrupted by the interviewer only to ask clarifying questions or to offer encouragement. A total of 9 participants were interviewed in total (8 female).

Results

At the six-month interviews, all of the participants disclosed they had viewed Brown as someone with power to detain them under the UK Mental Health Act due to her status as a mental health pharmacist, and had thus provided inaccurate responses to the baseline outcome measures. As one participant admitted, "the first time [I completed the forms] I was frightened of being locked up". Once identified, the nature of this dissembling became the focus of the qualitative interviews. Participants began to tell their stories of experiences with mental health services and professionals, but also their experiences of being part of CCD. Participants admitted they had dissembled due to a fear of mental health services (including a fear of being sectioned), a fear of Brown's power as a mental health professional and also due to self-deception.

The interviews were analysed using Grounded Theory (Glaser and Strauss, 1967) to generate a theory of therapeutic change. The analysis generated an overarching theory of congruence, adapted from Rogers' (1961) definition cited in the introduction. In CCD, TC peer relationships were understood as congruent. However, a fundamental aspect of congruence in these terms was the initial recognition of *personal incongruence*. Personal incongruence was identified through participant interviews as a fragmented self, social isolation, a crisis of faith and a lack of environmental 'fit'. It was reinforced through *pathogenic*, or harmful, relationships characterised by 'unequal power relationships' resulting in a loss of trust, feeling judged, and experiencing shame and fear. The pathogenic relationships described in this study related to parents, healthcare professionals, church authorities and friendships. As one participant illustrated:

I think as a patient you feel quite powerless. So if one doctor tells a nurse and the nurse tells so and so. The professionals listen to each other; they don't listen to you as a client.

Pathogenic relationships resulted in the participants adopting survival strategies in order to protect themselves from more shame and pain. These strategies included withholding information, dissembling or performing, which reinforced a fragmenting of self, loss of identity and social isolation:

I would appear to be smiling at times when actually I was completely disorientated and quite often with these health professionals they would be amazed at what they saw as my rapid progress... It wasn't progress at

all... I would manage to crack what I was being asked to do. ...but I wasn't reaching [pointing inside her chest].

In contrast, becoming personally congruent was identified in two main areas: a personal self and a social self. The process of becoming congruent with a personal self began with external sources, namely with the participant's relationships within the social environment. These relationships, termed *salugenic* (or health-producing; Clinebell, 1984), were voluntary, volitional and mutual, characterised by mutuality, hope, openness, safety, freedom and trust. Mutual positive relationships developed through sharing stories of personal positive change, as one participant explained:

When I first started seeing [another CCD member] she said, "I tell you what I can do for you. I can give you true, hopeful stories, not kind of clap trap stuff and not my life's perfect now and whatever." But I can authentically say that's where something has changed for me, that bit has changed. So I can share hope and I can do that with truth.

Clients identified that a congruent environment is where they feel they belong and where they can find hope, safety and freedom. The combination of congruent relationships and environment leads to the process of finding congruence with the self. As one participant framed the process:

And the general ethos here is one of hope. Even though I actually don't have any hope at the moment I can see that other people have hope and because if I like it or not, I have got relationship with people here, I find

it easier to not act on my self-harming and suicidal thoughts because out of relationship to them I don't want to hurt them.

In summary therefore, the theory of congruence proposes that individuals who have been socially isolated learn how to form salogenic relationships that facilitate personal, positive change through the expression of emotion. Congruent relationships positively impacts on clients' sense of self, leading to greater self-congruence.

Study 3

Method

S.P. Clarke's study used autoethnography to illustrate his experiences of the relational context of two treatment environments. As a methodology, autoethnography combines personal narrative ('auto') writing ('graphy') in order to reflect on, analyse, and explore particular socio-cultural practices and institutions ('ethno'; Anderson, 2006).

Autoethnography thus combines the conventions of autobiography in the retelling of 'epiphanies' with the explicit ethnographic goal of investigating the social world (Ellis, Adams & Bochner, 2011). It is a "methodology of the heart" (Sparkes, 2007) that employs the use of dramatic form in order to illustrate, challenge, educate and involve the reader (Ellis et al., 2013). It has also been used to illustrate the experiences of psychotherapy (Speedy, 2013) and mental health services (Short, Grant, & Clarke, 2007).

Results

In this article, two vignettes of S.P. Clarke's experiences of treatment environments are presented. The first account takes place in a psychiatric ward in 1994 and the second account describes an early visit in 2000 to an open TC where time was spent living in various types of

community living, including with families (where the second vignette is set). These accounts were based upon a number of unpublished sources including Clarke's NHS clinical notes, his therapy notes, a carer's diary and interviews with his friends and family. The interviews were conducted in an unstructured format in order to gain background information regarding Clarke's experience. Each account represents an amalgam of these different impressions in a similar way to Sparkes' (2007) methodology, and then told in the second person in order to 'induct' the reader into Clarke's experience. The two pieces are presented below and separated by three stars (***)

You are waiting for your first ward round. From the waiting room a cheerful nurse calls you in. She smiles pleasantly as she ushers you into a small room. The room is packed: there are at least seven people present. You weren't expecting this many people. Two middle-aged men in suits sit at the front introduce themselves as 'Consultants psychiatrists' and begin asking you questions.

Your anxiety rises. You sweat. You keep contradicting yourself. The two psychiatrists smile and seem to throw each other knowing glances. One of the nurses rolls her eyes – at you or at them? You don't know.

You have had enough. You mutter something in a quiet, barely audible, mumble. You walk out. The other doctor follows you out. You chat in a nearby room. The doctor asks why you left. He asks whether you will consider being an inpatient. No, you tell the doctor as you look through the barred windows that shimmer in the afternoon sun, I don't want to be an inpatient.

Suddenly and inexplicably the small doctor leaves the room. Was it something you said? You are not sure why he has left the room. What happens now? You open the door to the corridor and see the doctor running back to the ward round room. You don't know what to do. You are scared. There is a brief moment of hesitation and then you walk out of the hospital.

Outside, the warm September sun is all encompassing. You are in despair. All you have is this moment: the one, unflinching, unremitting sense of crushing despair, without hope of abatement or reprieve.

Slowly, like aspirin dissolving in water, your consciousness dissolves.

It is Easter and you are down for the week from London. The community has put you with this young family. The house is called Serendipity, which you are told means the occurrence and development of events by chance in a happy or beneficial way. The crash and suck of sea on shingle is heard in the background.

You are cleaning the ground story windows. The father tells you that it will keep the mind focussed and grounded. It's therapeutic, he says. And it is. You feel like you are offering something, giving something back.

Your consciousness is all broken up since the breakdown three months ago. Fragments of memories, occasional panicked thoughts, feelings, a phrase, a word, perhaps even fleeting desire; fear, hope, grief. The pieces slowly coalesce around the gentle intonation of a half-remembered poem:

Ah Sun-flower! weary of time,

Who countest the steps of the Sun:
Seeking after that sweet golden clime
Where the travellers journey is done.

Where the Youth pined away with desire,
And the pale Virgin shrouded in snow:
Arise from their graves and aspire,
Where my Sun-flower wishes to go.

You are that sunflower, you realise. The words hold both a promise and a certainty; there is hope in this grief. This is the trigger. The fragility breaks, finally. Things let go.

From inside the house you hear the distressed wail of the four-year old boy. Daddy, daddy, he cries, I've lost Simon! I've lost Simon! I can't find him! Daddy!

Around the corner they come, the little boy leading his father anxiously by the hand. They find you at the back window, bucket and wiper in hand. You are weeping uncontrollably, your body shuddering with sobs, tears streaming down your face into the bucket - salt water mixing with liquid detergent.

The father puts his hand on your shoulder and looks deep into your eyes. He takes the bucket from you.

Time to take a break, he says.

These two vignettes both portray psychological collapse. However, the 'affective resonance' of the two relational environments is very different. In the first vignette, which takes place in

a psychiatric hospital, there are clear relational hierarchies and the tone is impersonal and intimidating, creating a sense of fear and shame in the patient. Paradoxically, the confusion created by the ward round leads to the patient's complete psychological collapse. The second vignette takes place in an open-style TC characterised by a sense of kindness and gentle, familial discipline, whereby the signification of hope (expressed by the memory of Blake's Sunflower poem) also leads to psychological collapse. However, in this second scenario the collapse represents breakthrough, not breakdown.

Discussion

This article presented the findings from three studies that examined the quality of the relational experience as a core component of a mental health intervention. Although the three studies employed very different methods and theoretical approaches, a number of core themes emerged that were present across all of the studies. These themes will be explored in the following discussion.

The first theme arising from these three studies is the role of emotion and the relational 'climate' in terms of whether an environment is able to facilitate the expression, and then transformation, of negative affect. The studies demonstrate that allowing for the expression of emotion authentically in community, or 'permissiveness' (Rapoport, 1960) is a crucial first step in providing the foundations through which a successful therapeutic process is built. Crucially this process can be recognised within everyday interactions rituals (such as supporting one another during informal times), whereby individuals express their emotions together, building a sense of belonging and hope (Collins, 2004). In terms of the three studies, Brown showed that the sharing of stories could be an important community ritual that facilitates trust and safety within the relationships. In S.P. Clarke's study, everyday activities, such as washing windows in a safe family environment, can be the catalyst for the

transformation of despair into hope. Finally, J.M. Clarke highlighted how the sharing of negative emotion in the lounge of a residential TC engendered a release of intense negative feelings that were transformed into feelings of belonging. In this sense, an effective relational context is one that both contains difficult emotions, but then goes further by transforming the negative experiences into positive experiences such as hope and wholeness through mutuality and feelings of inclusion.

The role of emotional expression within therapeutic relationships is, of course, not a new idea but has a long history in psychotherapy, from Freud's notion of 'catharsis', to behaviourist notions of emotional facilitation and exposure (Rachman, 1980) and the work of Carl Rogers (1961). However, the relational qualities described in these studies arguably go further. Instead, it is relationships formed out of mutual experiences of understanding on the basis of which Buber (1937) called I-Thou, rather than just the '*verstehen*' of therapist empathy. Such 'expertise by experience' is more than simply a knowledge or awareness of distress, but an active expertise and experience of working through these experiences in relationships with like-minded peers that creates a group emotional IQ (Holmes & Williams, 2010) capable of facilitating a therapeutically congruent environment.

However, the authors would also argue that relational context and emotional expression are not enough by themselves to facilitate personal change. Two important factors identified in the three studies were belonging and hope. If there is no hope things can be different, then despair and inertia are likely to result. Conversely, when there is no sense of belonging in terms of the participant's identification with their social environment, in other words if the person is *incongruent* with their environment, then fear, inauthenticity and isolation are liable to result.

Hope is of course foundational to many spiritually-informed psychotherapeutic approaches (Pargament, 2011). It has long been recognised by the Recovery movement as

central to the experience of successful rehabilitation from severe mental illness, as well as a useful corrective against the overly pessimistic character of some psychiatric classification systems (Slade, 2009). However, many contemporary models of recovery miss the communal dimension and instead posit the recovery journey in entirely individualistic terms (Winship, 2016). The authors of these three studies would argue that hope is impossible without some notion of belonging to a community of like-minded individuals. In many ways, it is one's peers and community that are able to hold a vision of hope that is then transmitted to newer members, who may not have the capacity to generate hope on their own.

The final theme that arose from the three studies is whether the relational hierarchies of a mental health environment are able to facilitate emotional expression, hope and belonging. J.M. Clarke observed that TC relational structures can either be rigid and hierarchical, thus leading to exclusion and negative emotional expression, or they can be more 'fluid' and generate the positive emotional expression necessary for personal change. Similarly, Brown's and S.P. Clarke's studies the relational structures of the psychiatric system were contrasted negatively against the more egalitarian structures of an open TC whereby members felt able to be more authentic in their expression of negative affect without fear of institutional censure. For example, in Brown's study a fluid hierarchy can be observed even in a non-professionalised role, whereby more experienced TC members may take a guiding role (e.g. sharing personal stories and offering support to newer members). In S.P. Clarke's study, the family structure provides a safe, yet temporary, relational structure where both the expression of emotion and community responsibilities were held together.

Rather than a flattened hierarchy model advocated by many TC writers, a model of fluid hierarchy (Clarke, 2015) acknowledges clients at any one point might hold differing levels of power and social status. Furthermore, a fluid hierarchy model still allows for deliberate efforts to minimise power imbalances between staff and clients through shared

responsibility and changing roles, whilst realistically acknowledging that at times, hierarchal components and power imbalances exist within the client cohort. This in itself is not problematic as long as positive feelings remain *shared* and clients do not become alienated, marginalised or isolated. What is central is whether these power roles become flexible or rigid resulting in emotional power imbalances. This follows Haigh (2013) who argues, '[a]uthority is fluid and questionable – not fixed but negotiated' (p. 13). Flexible social roles suggest that there is room for client members to change their social position and that the community allows for shifts in its hierarchy without power being consolidated in any one individual(s), staff or client.

The history of mental health services is often marked by a failure to adequately democratise and make use of patient expertise (Noorani, 2013). A notable exception to this are TCs who, from their earliest conception in the post-World War II experiments of hospitals of Northfield and Mill Hill, attempted to subvert the natural order of staff/patients and create a genuinely patient-led therapeutic endeavour (Winship, 2013). These attempts were crystallised in the phrase 'flattened hierarchy', a concept which is considered to be one of the key components of a well-functioning TC (Manning, 1989). However, along with Bloor, McKeganey & Fonkert (1988), we acknowledge "the Foucauldian view of power as a strategic relationship, a routine fact of social life in therapeutic communities as elsewhere" (p. 190). Thus, the notion of a 'flattened hierarchy' does not adequately capture the complexities of relations in therapeutic environments. We would therefore suggest Clarke's (2015) notion of a 'fluid' hierarchy as a more accurate depiction of the positions and roles different people may take at different times, and emphasises the importance of belonging and mutuality being shared by all clients.

In summary, this article presented three studies that, together, shed light on aspects of the relational context that can either afford positive psychological change, or hinder it. These

factors include the expression and containment of affect in a congruent environment, belonging and hope, and fluid hierarchies of relational structures. We believe these factors provide the basis by which the relational context of all mental health interventions, and not just TCs, can be better understood.

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